MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES

GROUND AMBULANCE SERVICE LICENSE APPLICATION

FOR DOH OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

☐ INITIAL LICENSURE	AMBULANCE SERVICE LIC. #		DATE PASSED INSPECTION
☐ RELICENSURE	DATE APPLICATION RECEIVED		DATE LICENSED
INSPECTOR ASSIGNED _____	DATE INSPECTOR ASSIGNED		EXPIRATION DATE
	DATE OF FIRST INSPECTION		

APPLICANT MUST COMPLETE INFORMATION BELOW ***TYPE OR PRINT***

1. TRADE NAME OF AMBULANCE SERVICE ***(Name on vehicle)*** | **NUMBER OF VEHICLES**

LOCATION OF AMBULANCES *(STREET, ROUTE, CITY, STATE, ZIP)*

☐ BLS ☐ ALS

2. OPERATOR OF AMBULANCE SERVICE

NAME OF OPERATOR | NAME OF MANAGER (LAST, FIRST, MI) | TELEPHONE NUMBER-BUSINESS

OPERATOR MAILING ADDRESS *(STREET, ROUTE, ETC.)* | TELEPHONE NUMBER-EMERGENCY

CITY | STATE | ZIP CODE | E-MAIL | FAX NUMBER

3. MEDICAL DIRECTOR

NAME *(LAST, FIRST, MI)* ☐ MD ☐ DO

MAILING ADDRESS *(STREET, ROUTE, ETC.)* | OFFICE TELEPHONE NUMBER

CITY | STATE | ZIP CODE | E-MAIL | FAX NUMBER

☐ BOARD CERTIFICATION ☐ ACLS ☐ ATLS ☐ PALS ☐ LETTER OF AGREEMENT

I HEREBY CERTIFY that I am aware of the qualification requirements and the responsibilities of an ambulance service medical director (*190.103 RSMo Supp. 1998 & 19 CSR 30-40.303*) and I agree to serve as medical director.

SIGNATURE OF AMBULANCE SERVICE MEDICAL DIRECTOR | DATE

4. CONSULTANT MEDICAL DIRECTOR

NAME *(LAST, FIRST, MI)* ☐ MD ☐ DO

MAILING ADDRESS *(CITY, STATE, ZIP CODE)* | OFFICE TELEPHONE NUMBER

☐ BOARD CERTIFICATION ☐ ACLS ☐ ATLS ☐ PALS ☐ LETTER OF AGREEMENT

I HEREBY CERTIFY that I am aware of the qualification requirements and the responsibilities of an ambulance service medical director (*190.103 RSMo Supp. 1998 & 19 CSR 30-40.303*) and I agree to serve as consultant medical director.

SIGNATURE OF AMBULANCE SERVICE CONSULTANT MEDICAL DIRECTOR | DATE

5. AMBULANCE SERVICE LICENSEE

NAME OF POLITICAL SUBDIVISION OR CORPORATION | NAME OF CEO | TELEPHONE NUMBER-BUSINESS

BUSINESS MAILING ADDRESS *(STREET, ROUTE, ETC.)* | TELEPHONE NUMBER-EMERGENCY

CITY | STATE | ZIP CODE | E-MAIL | FAX NUMBER

I HEREBY CERTIFY that this application contains no misrepresentations or falsifications and that the information given by me is true and complete to the best of my knowledge. I further certify that the above named Ambulance Service has both the intention and the ability to comply with the regulations promulgated under the Comprehensive EMS Act, Chapter 190, RSMo 1998.

I have attached all Ambulance Service licensure and related administrative licensure actions taken against this ambulance service or owner by any state agency in any state.

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF AMBULANCE SERVICE LICENSEE | DATE

WARNING; In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor. Missouri Statutes 575.060.

Mail Application to: Bureau of Emergency Medical Services, P.O. Box 570, Jefferson City, MO 65102